Insurance Partnership

Commonwealth of Massachusetts
Division of Medical Assistance

Employer Application

Complete one application for each federal employer identification number (FEIN) or equivalent.

This application contains (check (✓) one): ☐ new information ☐ revised information

Effective date of new or revised information: ____/____/____

Section 1 - Employer Information

FEIN or equivalent: _____

Corporate address (legal entity)

Legal entity name		Attn.		
P.O. box (if applicable)	Street address	City	State	Zip
Telephone number ( )		Fax number ( )		

Doing business as (DBA) If the business has more than one DBA address, attach a separate sheet with the other addresses.

DBA name		Attn.		
P.O. box (if applicable)	Street address	City	State	Zip
Telephone number ( )		Fax number ( )		

Mailing address (if different)

Business name		Attn.		
P.O. box (if applicable)	Street address	City	State	Zip
Telephone number ( )		Fax number ( )		

Business start date: ____/____/____

Nature of business: _____

Standard industrial code: _____

Number of full-time employees (who are scheduled to work 30 or more hours a week): _____

Number of employees who are eligible for health insurance through your business: _____

over ▶

Section 2 - Insurance Information

Please provide the information requested below for each policy tier of the health plan you offer. If you contribute different amounts based on employee type (for example, full-time vs. part-time, or union vs. non-union), specify in the last three columns of the chart the amount you contribute for each type using the following codes:

Employee Type Codes†				
	FT = full-time	MA = management	UN = union	NX = nonexempt
	PT = part-time	NM = nonmgmt	NU = nonunion	OT = other

If you offer more than one health plan, please copy this section and attach a completed copy for each additional plan you offer.

Health plan name: _____ Group number: _____

Policy tier	**Date began contributing at least 50%** (mm/yy)*	**Total premium**	**Employer contribution for type code†** ____	**Employer contribution for type code†** ____	**Employer contribution for type code†** ____
☐ Individual	/	$	$	$	$
☐ Family	/	$	$	$	$
Two-person policies (if offered)					
☐ Couple (two adults)	/	$	$	$	$
☐ Dual (one adult, one child)	/	$	$	$	$

*If the date you began contributing at least 50% toward health insurance is before 1996, an approximate year is sufficient.

Please indicate below the period during which the rates are effective:

Start date: ___/___/___ End date: ___/___/___

Section 3 - Employer Rules and Responsibilities

By signing below, the employer agrees to do all of the following:

- Treat all employee data received from the Commonwealth confidentially and in accordance with the requirements of the Fair Information Practices Act (M.G.L. c. 66A), whether or not the person is still an employee or the employer is participating in the Insurance Partnership.
- Report any changes to any information requested on this form to its Insurance Partnership administrative entity within 10 business days of the change.
- Agree to adjust any qualified employee's payroll withholdings related to health-insurance coverage by the amount of premium assistance payments issued by the Division, as soon as possible, but no later than 30 days after notification of the premium assistance amount.
- Submit monthly health-insurance premiums by the due date of the premium bill.
- Resolve overpayments and underpayments as directed by the Division and/or the appropriate Insurance Partnership administrative entity.

If determined eligible for the Insurance Partnership, _____
Business name

will comply with all rules listed above and with the provisions of the Division's regulations governing participation in the Insurance Partnership, found at 130 CMR 650.000. (A copy of the regulations will be provided by the Insurance Partnership administrative entity from which you received this application.) I understand that my business may be terminated from the Insurance Partnership if it fails to follow any of the above rules or the regulations at 130 CMR 650.000. I further understand that my business's termination from the Insurance Partnership may also result in the termination of premium assistance for my employees.

I certify under penalty of perjury that the information provided on this application is correct and complete to the best of my knowledge.

Employer's signature	Title	Date
		/ /

Print Form